S. No. 2
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2434

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 21 1946

State File No. 225

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 114

1. PLACE OF DEATH:

(a) County ~~Homer G. Hospital~~

(b) City or town St Louis Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: HOMER G. PHILLIPS HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution three days (Specify whether

In this community 15 months (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County 200 2 (1)

(c) City or town St Louis Mo (If outside city or town limits, write "RURAL")

(d) Street No. 1929 R carr st (If rural, give location) 9 10

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Josephus Davis

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M 2

5. Color or race Col

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive years

7. Birth date of deceased August 4 (Month) 4 (Day) (Year)

8. AGE: Years 1 Months 4 Days 27 If less than one day hr. min.

9. Birthplace Miss (City, town, or county) 1 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Josephus Davis
13. Birthplace Alla (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Luedella Greed
15. Birthplace Alla (City, town, or county) 1 (State or foreign country)

16. (a) Informant Josephus Davis

(b) Address 1929 R carr

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-5-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Macon, Miss

18. (a) Signature of funeral director Lee J. Sneed

(b) Address 3615-17 Easton ave

19. (a) JAN 5 1946 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 1st year 1946 hour 11 minute 30 a M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 3

23. Signature Patrick E Ivy Co (M.D. or other)

Address Dey Co Date signed 1/3/45

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ ——, Registered Apprentice No. ——, working under my personal supervision.

Signed Chas. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.